# Medicine and society

# The strange absence of things in the "culture" of DSM-5

Stefan Ecks, Social Anthropology, University of Edinburgh

Stefan.ecks@ed.ac.uk

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DSM-5 contains a far more detailed exposition of the place of "culture" in psychopathology than any previous edition of the manual. At the same time, "culture" has also become the basis from which two of the major attacks on DSM-5 have been waged. The whole DSM project risks unravelling if "culture" is not addressed in substantially different terms. One crucial revision must be to recognize pharmaceutical uses as a part of "culture."

DSM-5 comprises three sections on culture. "Cultural Issues" are first mentioned in the Introduction ([1] APA 2013: 14-15). A chapter is devoted to "Cultural Formulation," which extends the discussion of culture and outlines the "Cultural Formulation Interview" (749-759). The "Glossary of Cultural Concepts of Distress" (833-837) lists well-documented syndromes such as *ataque de nervios*, *dhat*, or *susto*.

DSM-5 echoes classic definitions from cultural anthropology. "Culture" is said to be the totality of norms and values held by individuals, families, social systems, and

institutions. Culture encompasses "systems of knowledge, concepts, rules, and practices" (APA 2013: 749). Language, religion, spirituality, kinship, rituals, and laws are all part of culture. One becomes a member of a culture by internalizing shared norms and values.

DSM-5 lists many areas where culture matters for psychiatric practice. Culture provides patients with an "interpretive framework" that shapes both the "experience" of mental distress and its "expression." Cultures vary by their "thresholds of tolerance" for symptoms and behaviors: what is still "normal" and what is already "pathological" will differ according to cultural norms and expectations. The previous concept of "culture-bound syndromes" is rejected and replaced by "cultural syndromes," "cultural idioms of distress," and "cultural explanation/perceived causes."

The most surprising sections bend the culture concept back onto DSM itself. It has often been said that DSM classifications will always be uncertain, arbitrary, or nothing more than the results of horse-trading in committee meetings (e.g., [2] Shorter 2013). Most assumed that the authors of DSM would never part from ahistorical truth claims and be "reluctant to see their creations as historical, cultural, ideological products rather than as scientific documents" ([3] Phillips 2013: 159). Yet DSM-5 took these culturalist criticisms on board and made them its own: "Like culture *and DSM itself*, cultural concepts may change over time in response to both local and global influences" (APA 2013: 758; my emphasis). All the diagnostic labels used in the DSM had specific cultural origins: "The current formulation acknowledges that *all* forms of distress are locally shaped, including the DSM disorders" (APA 2013: 758; emphasis in the original).

If the APA acknowledges that DSM is itself a product of "culture" and that all its

categories as "locally shaped," where does this leave the argument that DSM leads to the medicalization of normal feeling and behaving? This criticism has been made against DSM for decades, but has never been as vociferous as now. The British Psychological Society ([4] 2011), for example, published a manifesto against "the continued and continuous medicalisation of … natural and normal responses." The presentation DSM-5 in the mainstream media took a similar position and worried about how "abnormal is the new normal." The argument runs that DSM-5, more than any previous version, devalues cultural patterns of feeling and behaving in favor of excessive medical interventionism.

A prominent voice against medicalization is Allen Frances, chairman of the DSM-IV Task Force. Frances predicts "a bonanza for the pharmaceutical industry but at a huge cost to the new false positive 'patients' caught in the excessively wide DSM-V net" ([5] 2009). His argument rests on a culturalist position: there are, he says, long-established cultural patterns of feeling and behaving in a "normal" way, which DSM-5 tries to destroy. For example, the removal of the bereavement exclusion from the diagnosis of depression was an attempt at medicalizing normal sadness and to turn it into a psychiatric condition: "Turning bereavement into major depression would substitute a shallow, Johnny-come-lately medical ritual for the sacred mourning rites that have survived for millenniums" ([6] Frances 2010). It is not without irony that Frances, who supressed a significant expansion of "culture" in DSM-IV, would turn into an *über*-culturalist, but this is what has happened.

Another attack on DSM-5 came from within biopsychiatry and focused on the manual's "lack of validity." Shortly before DSM-5 was launched, Thomas Insel, director of the NIMH, ridiculed the DSM approach to disease classification as an intuitive art rather

than a hard science: "DSM diagnoses are based on a *consensus* about clusters of clinical symptoms, not any objective laboratory measure" ([7] Insel 2013; my emphasis). Because DSM could never move beyond mere opinions arrived at through consensus decisions, the NIMH "will be re-orienting its research away from DSM categories." Doubts about the validity of DSM classification go back more than a decade and were a key part of the post-DSM-IV revision agenda. The failure of DSM-5 to make any progress in this area has turned this doubt to dread.

Clearly the medicalization critique is a kind of *cultural* critique (see [8] Pickersgill 2013). It is less obvious that the biopsychiatric argument against DSM-5 *also* comes from a culturalist position. When Insel finds that DSM is based on a "consensus" rather than objective measures, he is making the same point that Frances and the critics of medicalization have been making all along: that DSM is produced by a human, all-too-human community of psychiatrists, and that their ideas about psychopathology are mere conventions.

Neither group of critics seem to have noticed, however, that DSM-5 might find a defense against these attacks in its culture sections. Could the authors of DSM-5 not turn around and say that both the "medicalization" and the "lack of validity" allegations have already been acknowledged and answered because everything is now "culture," including DSM?

The culture sections provide a kind of apology for DSM. But seems like a shallow apology. Why is it shallow? It is shallow because what is presented as "culture" in DSM-5 is too focused on meaning and not enough on practice.

DSM-5's culture sections are based on the hermeneutic, meaning-centered tradition in anthropological theory. This approach is good at dealing with ideas, but it is bad at grasping material, nonhuman *things* that co-constitute everything that humans experience. Attempts at defining culture without things were popular in the 1980s, but not much since then. There have been several material, praxiographic, and habitographic turns in anthropology (e.g., [9] Mol 2002), and even a brief engagement with them should have changed the culture sections in DSM-5.

*Things* matter in psychiatry. There are many things that change how psychiatrists detect, diagnose, and treat mental illnesses. One kind of material artifact that makes a huge difference is the psychopharmaceutical. There are many examples for why drugs matter. Drugs matter for research: DSM classifications and psychopharmacology have been developing hand in hand since DSM-III. Clinical trials for various compounds need to enroll patients with specific problems rather than a diffuse spectrum of complaints. The more specific the diagnosis, the easier it is to conduct trials and to provide the evidence needed to get market approval. Drugs matter for diagnostic practices: most psychiatrists first consider what kind of drug might work on a particular patient, and tailor their diagnoses toward that. Drugs matter for patients' expectations and demands toward doctors. Direct-to-consumer marketing, especially in North America, asks patients to see immediate links between illnesses and drugs, putting pressure on prescribing doctors ("ask your doctor if drug X is right for you"). Drugs matter because they shift what is "culturally" normal. For example, "cultures of bereavement" are not immune to the availability of antidepressants or tranquillizers. There are countless loops between drugs and cultural expectations (e.g., [10] Elliott 2011). In my ethnographic work on changing notions of mental illness in India ([11] Ecks 2013), I would not know how to use the culture sections of DSM-5 because

everything I encounter hinges on the uses of psychopharmaceuticals.

Both the "medicalization" critique and the "lack of validity" critique also point to missing materialities in DSM-5, be it the overuse of psychotropic medications or the absence of biogenetic substrates. If DSM-6 wants to be relevant, it needs to account for things that matter in both its diagnostics *and* its definitions of culture.

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